IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

July 13, 2010

Lenny Checkettes
Mercy Medical Center
1512 Twelfth Avenue Road
Nampa, ID 83686

Provider #130013

Dear Mr. Checkettes:

On **June 2, 2010**, a complaint survey was conducted at Mercy Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004068

Allegation: The hospital discharged a patient to a facility for which he was not qualified.

Findings: An unannounced visit was made to the hospital on 5/24/10-6/02/10. Medical records were reviewed. Staff was interviewed.

Seven medical records were reviewed for discharge planning. All of the records documented patients received an assessment of discharge planning needs. All of the records documented a discharge plan. All of the records documented staff working with patients and families to implement the discharge plan.

One record documented a 54 year old male who was admitted to the hospital on 2/25/09 and was discharged on 3/17/09. Diagnoses included encephalopathy, hepatitis, and acute renal insufficiency. Extensive discharge planning was documented throughout his stay. He was discharged to an Assisted Living Facility. for admission to their facilities.

All cases reviewed received appropriate discharge planning.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As the complaint was not substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srp

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July 19, 2010

Joseph Messmer
Mercy Medical Center
1512 Twelfth Avenue Road
Nampa, ID 83686

Provider #130013

Dear Mr. Messmer:

On **June 2, 2010**, a complaint survey was conducted at Mercy Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004115

Allegation #1: The hospital violated patient privacy laws by sending her another patient's clinical information.

Findings #1: An unannounced survey was made to the hospital May 24 through May 26. The investigation was completed on June 2. During the complaint investigation, surveyors interviewed medical record staff and billing staff. They also reviewed Release of Medical Information documents, hospital policies, and patient grievances.

During an interview on 5/24/10, the Director of Patient Financial Services stated that when individuals called stating they received bills that did not belong to them, she referred the information to the HIPPA Privacy Officer for investigation. She stated the billing office personnel did not release any medical information upon request. Instead they referred requests to the Medical Records Department for proper authorization and release of records. She stated the billing office personnel would send billing statements upon request that showed itemization of billing charges. The bills would not include doctor names or diagnoses or personal medical information.

The hospital's policy, "Releasing Patient Information," dated 8/08, stated that no

copies of medical records were to be released to patients or their legal representatives without photo identification. The hospital's policy was to refuse to honor a written authorization if there was reasonable doubt as to the identity of the person presenting the authorization, or evidence that the person requesting information was not the person named in the authorization.

During an interview on 5/24/10, the Medical Records Coding Supervisor confirmed it was the hospital's policy and practice to require signatures and identification, such as a copy of a driver's license, prior to releasing medical records. When asked if the hospital had received any complaints of having sent someone another person's medical records, she denied being aware of any such complaints. The hospital's Grievance Log was reviewed from June 2009 to current. There were no complaints documented that the hospital violated patients' privacy by sending unauthorized medical records.

During an interview on 5/24/10, a Medical Records Technician stated if she had suspicions that a person requesting clinical information was not authorized to do so, she would not release the information and would alert the hospital's Risk Manager.

On 5/24/10 the Release of lnformation Specialist provided, upon request, copies of the last 5 requests for release of information. All of the record release forms were signed by the patient or authorized individual with copies of identifying information, such as drivers licenses or papers showing the legal relationship to the patient.

On 5/25/10 the HlPPA Privacy Officer was interviewed. She explained she developed and maintained hospital policies related to ensuring patient privacy and educated staff regarding these policies. She also explained she kept track of and investigated any allegations that the hospital violated patient privacy. When asked if there had been complaints about someone receiving someone else's records, she stated they had occasionally had problems. For example, faxes had accidentally been sent to the wrong phone number when an employee transposed a phone number. In order to reduce the chance of faxing errors, the hospital had developed a policy to limit who could receive medical records by fax. She stated requests from private parties were handled in person or via mail, rather than fax, to reduce the chance of error. She stated that another error that had been discovered was when someone's medical information (usually a single piece of paper) had been misfiled in another person's chart and inadvertently sent with a request. If her investigation of complaints led her to believe patient privacy was violated as a result of employee error, then employees would receive appropriate discipline and or re-education. She described one incident of privacy violation that involved identity theft. The police became involved with the case.

It appeared the hospital had measures in place to reduce the risk of releasing medical information inappropriately. It also had measures in place to track errors and put in corrective measures. It could not be determined the hospital violated patient privacy laws by inappropriately sending patient clinical information to unauthorized individuals.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Teresa J Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srp

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July 19, 2010

Joseph Messmer
Mercy Medical Center
1512 Twelfth Avenue Road
Nampa, ID 83686

Provider #130013

Dear Mr. Messmer:

On **June 2, 2010**, a complaint survey was conducted at Mercy Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004151

Allegation #1: The hospital did not provide care to prevent and/or treat pressure ulcers.

Findings #1: An unannounced visit was made to the hospital on 5/24/10 through 6/02/10. Staff were interviewed and 23 medical records were reviewed. Patients were interviewed. Policies were reviewed.

One medical record documented a 75 year old female who was admitted to the hospital on 5/26/09 for placement of a suprapubic catheter and a pubovaginal sling. She was discharged home on 5/28/09. Her admission nursing assessment documented four pressure ulcers on her sacrum, buttocks, abdomen, and thigh and 5 reddened areas under her breasts, in her perineal area, and on her right foot. However, a specific plan to treat her skin break down was not developed until over 24 hours following her admission. She was evaluated and treated by a wound care nurse on 5/27/09. Otherwise, care rendered by nursing staff to treat her skin break down and care to prevent further skin were not documented. Her medical record documented her skin break down was worse at discharge than when she was

these records lacked documentation of plans of care to treat their skin break down. One of these records lacked documentation of treatment for skin break down. Deficiencies were cited at 42 CFR Part 482.23(b, 3 and 4) for the failure of the hospital to develop plans of care to treat skin break down and for the lack of treatment to prevent skin break down.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: A patient required a blood transfusion due to bleeding from a worsening pressure ulcer.

Findings #2: Four medical records were reviewed for care related to pressure ulcers. One of these medical records documented a patient who was very anemic on admission. Her hemoglobin was 7.7 on 5/26/10 at 5:30 PM and had decreased to 6.9 on 5/27/10 at 5:25 AM. Nursing notes documented that she had some bleeding from a pressure ulcer. A physician consultant noted a 4 centimeter by 4 centimeter wound that was "bleeding slightly" at 8:13 PM on 5/26/10. The physician did cauterized the wound with silver nitrate. The patient was transfused with 2 units of packed red blood cells for her anemia. Her hemoglobin had risen to 8.1 on 5/28/10 at 5:45 AM. Her worsening anemia did not appear due to significant bleeding at the hospital. Anemia was not a concern with the other 3 records.

No sampled patients required transfusions due to bleeding wounds. All sampled patients received medical care in response to their needs.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: A patient had an abscessed tooth which was not treated.

Findings #3: Medical records of 23 patients were reviewed. None of these patients had a diagnosis of an abscessed tooth. One medical record documented a 75 year old female who was admitted to the hospital for surgery on 5/26/09 and was discharged home on 5/28/09. The discharge orders on 5/28/10 at 10:30 AM stated the patient "...will have postauricular node/salivary gland enlargement evaluated as outpatient as it seems to be getting smaller and less painful." This information was included in discharge planning instructions to the patient.

A physician evaluated the enlarged gland and made a decision not to treat the condition in the hospital. No deficient practice was identified.

A physician evaluated the enlarged gland and made a decision not to treat the condition in the hospital. No deficient practice was identified.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srp

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July 21, 2010

Joseph Messmer
Mercy Medical Center
1512 Twelfth Avenue Road
Nampa, ID 83686

Provider #130013

Dear Mr. Messmer:

On **June 2, 2010,** a complaint survey was conducted at Mercy Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004423

Allegation #1: Nursing staff did not respond to requests for pain medication in a timely manner.

Findings #1: An unannounced complaint investigation was conducted on 5/24/19-6/02/10. During the complaint investigation surveyors reviewed clinical records, hospital policy and procedures and interviewed patients and staff.

Five patients were interviewed regarding nursing staff's response to requests for pain medication. Patient interviews confirmed a delay between staff answering the call light and staff responding to patient needs. However, none of the five patients expressed concerns regarding said delays.

A review of the hospital's comprehensive policy titled, "Pain Management Multidisciplinary Policy and Procedure," last revision 11/09, instructed staff to "Assess characteristics of pain..."

Further, the policy stated "A positive response to pain assessment, either verbal or non-verbal, requires intervention and reassessment following intervention. The

patient's pain status is reassessed at least once a shift, 30 minutes to one hour after the pain relieving interventions or medication administration, and as needed."

Additional records reviewed documented patients received pain medications per physician orders. However, there was no documentation that patients' pain level and characteristics were reassessed 30 minutes to an hour after each time pain medication was given.

The lack of re-assessment of patients' response to the medication limited the hospital staffs' ability to effectively manage patients' pain and make recovery as comfortable as possible.

Staff failed to follow the facility pain management policy related to documentation of the pain assessment which was to include: characteristics of pain, level of pain, re-assessment of pain level, and characteristics after administration of pain medications, to determine the effectiveness of the medication.

Hospital staff did not document the effectiveness of pain medications to determine if additional interventions or medications were needed. The hospital was cited for these deficiencies.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srp

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E-mail: fsb@dhw.idaho.gov

June 16, 2010

COPY

Lenny Checkettes
Mercy Medical Center
1512 Twelfth Avenue Road
Nampa, ID 83686

RE: Mercy Medical Center, provider #130013

Dear Mr. Lenny Checkettes:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on June 2, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction form, CMS-2567, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for Medicare deficiencies. If you do choose to submit a plan of correction, provide it in the spaces provided on the right side of each sheet. It is important that your Plan of Correction address each deficiency in the following manner:

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the POC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by **June 29, 2010**. Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

RN FOR

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srp
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130013	A. BUILDING _____ B. WING _____	C 06/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY MEDICAL CENTER	1512 TWELFTH AVENUE ROAD NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your hospital. The surveyors conducting the survey were: Teresa Hamblin, RN, MS, HFS Gary Guiles, RN, HFS Gary Banister, RN, HFS Acronyms and terms used in this report include the following: ALF = assisted living facility doh = date of hire ED = emergency department eMAR = electronic medication administration record GU = genital/urinary Integumentary = relating to the skin MAR = medication administration record PAI MGT = pain management POC = plan of care RES THE = respiratory therapy RN = registered nurse SKI INT = skin interventions SUP CAT = suprapubic catheter	A 000	RECEIVED JUN 24 2010 FACILITY STANDARDS	
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on staff interview and review of medical	A 168		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Interim Pres. Asst | (X6) DATE: 6/21/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that o' safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days fc ng the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 168	Continued From page 1 records and hospital policies, it was determined the hospital failed to ensure restraints were used in accordance with complete physician orders in 3 of 4 restrained patients (#1, #13, and #16) whose records were reviewed. This had the potential to interfere with coordination and safety of patient care. Findings include: A hospital policy, "Restraints/Seclusion," last revised 2/09, stated restraint orders were to specify the reason for ordering restraints, the type of restraints, and the duration of restraints. All physician orders were to be documented in the paper medical record (as opposed to the electronic medical record). The following patient records illustrate incomplete or potentially missing physician restraint orders. 1. Patient #1 was a 56 year old woman. Her medical records documented the following incomplete restraint orders: a. An "Emergency Physician Record," dated 8/03/09, documented Patient #1 was brought to the ED by police due to agitation. An RN assessment note, dated 8/03/09 at 10:37 AM, documented Patient #1 was put in leather restraints (escorted by 3 police officers) due to extreme agitation and inability to control herself. A physician's order documented on a form called "Violent Adult (Behavioral) Restraint Order," dated 8/03/09 at 10:05 AM, failed to indicate the type of restraints to be applied to Patient #1 or the reason for the restraints. The physician's order was incomplete. During an interview on 5/25/10 at 10:15 AM, ED RN #1 reviewed Patient #1's medical record and confirmed the physician's	A 168		

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A 168	Continued From page 2 restraint order documentation was incomplete for the ED record on 8/03/09. b. An "Emergency Physician Record," dated 1/03/10, indicated Patient #1 was brought again to the ED by police due to being "out of control." The Emergency Physician's Record," dated 1/03/10, documented the patient was angry, agitated, hostile, uncooperative, and abusive, with a clinical impression of psychosis and alcohol intoxication. A signed, but undated and untimed, physician's order was documented on a form called "Violent Adult (Behavioral) Restraint Order." The order was for soft four point restraints. Failure to date and time the restraint order indicated an incomplete physician's order. During an interview on 5/25/10 at 9:40 AM, the Clinical Nurse Educator reviewed Patient #1's medical record and confirmed the physician restraint order documentation for 1/03/10 was incomplete. 2. Patient #13 was a 43 year old female who was transported via ambulance to the ED on 2/08/10. A physician's order for restraints, dated 2/08/10 at 11:00 PM, failed to describe the type of restraints to be applied or the clinical justification for the restraints. The physician's order was incomplete. An RN note, dated 2/08/10 at 11:00 AM, documented application of four point soft restraints for medical reasons. During an interview on 5/25/10 at 10:15 AM, ED RN #1 reviewed Patient #13's medical record and confirmed incomplete physician restraint order documentation. 3. Patient #16 was a 30 year old male who arrived at the ED on 12/11/09 via police escort. A	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 168	Continued From page 3 physician's order for two point restraints, dated 12/11/09 at 7:30 PM, was documented on a form titled "Violent Adult (Behavioral) Restraint Order." The restraint order failed to include the specific type of restraint (whether soft or leather or other). It also failed to specify which limbs were to be restrained and the clinical justification for the restraints. A nursing note, dated 12/11/09 at 7:30 PM, documented police had handcuffed the patients arms to the bed and soft restraints had been applied to his legs. During an interview on 5/25/10 at 10:15 AM, ED RN #1 reviewed Patient #16's medical record and confirmed the physician's restraint order documentation was incomplete. Orders for restraints were not complete.	A 168		
A 175	482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD is not met as evidenced by: Based on staff interview and review of patients' medical records and hospital policies, it was determined the hospital failed to ensure 2 of 2 behaviorally restrained patients (#1 and #16) who had police present in the room, were monitored by trained staff at intervals determined by hospital policy. This had the potential to interfere with quality and safety of patient care. Findings include: A hospital policy, "Restraints/Seclusion," issued	A 175		

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A 175	Continued From page 4 7/05 and revised 2/09, stated patients in behavioral restraints were to receive one-to-one (continuous in person) monitoring (both visual and auditory observation) at all times. The monitoring was to be performed by an assigned staff member who was competent and trained in the use of restraints. The policy also stated trained staff were to monitor and evaluate patients at least every 15 minutes, and more frequently as needed. Monitoring was to include the following: 1. Nutrition and hydration status; 2. Circulation; 3. Range of motion; 4. Vital signs (exclusive of temperature); 5. Hygiene status; 6. Elimination needs; 7. Physical distress, status and comfort; 8. Current behavior and psychological status and comfort; 9. Signs of injury associated with restraint use; 10. Readiness for release from restraint. The policy did not address the use of police officers as sitters. During an interview on 5/25/10 at 10:15 AM, ED RN #1 stated police were used as sitters and they made "good babysitters." During an interview on 5/26/10 at 11:00 AM, the Vice President of Patient Care Services was interviewed. He stated he thought police could serve as sitters but acknowledged police were not hospital staff, their use as sitters was not addressed in the hospital's restraint policy, and that the hospital had not investigated or documented the specific training police had received in monitoring patients in restraints.	A 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 175	Continued From page 5 The following patient examples make three points: 1) The interval for monitoring, in some cases, exceeded the 15 minute minimum requirement stated in hospital policy. 2) Monitoring and/or documentation of monitoring failed to meet expectations stated in the hospital's restraint policy. 3) Police officers, who were not staff members and whose restraint training was not monitored by the hospital, were being used in the role of patient sitters. 1. Patient #1 was a 56 year old female who was restrained during 2 separate ED visits. Concerns related to the monitoring of Patient #1 while she was restrained include: a. An "Emergency Physician Record," dated 8/03/09, indicated Patient #1 was brought to the ED by police due to agitation. An RN assessment note, dated 8/03/09 at 10:37 AM, documented Patient #1 was put in leather restraints upon arrival (escorted by 3 police officers) due to extreme agitation and inability to control herself. The first documented RN assessment after the initial RN note, dated 8/03/09 at 11:27 AM, was 50 minutes after application of leather restraints (35 minutes beyond the minimum required time for restraint monitoring according to hospital policy). The RN note documented Patient #1 had good circulation, was able to move all her extremities, and remained combative and agitated with all attempts at care. There was no documentation to indicate Patient #1's vital signs were taken or nutritional, hydration or elimination needs were assessed or addressed. An RN note, dated 8/03/09 at 11:50 AM,	A 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 175	Continued From page 6 documented Patient #1 remained in restraints and that "Region 3 and family" were present at her bedside. There was no evidence of continuous patient monitoring by an assigned staff member who was competent and trained in the use of restraints. During an interview on 5/26/10 at 10:50 AM, the Vice President of Patient Care Services reviewed Patient #1's record and confirmed ED documentation failed to show consistent monitoring of patients in restraints every 15 minutes according to hospital policy. He also confirmed the use of police (non-staff members) as sitters. b. An "Emergency Physician Record," dated 1/03/10, indicated Patient #1 was brought to the ED by police due to being "out of control." The physician documented his clinical impression: psychosis and alcohol intoxication. An undated, untimed, "Violent Adult (Behavioral) Restraint Order" included an order for soft four point restraints. The clinical justifaction for restraints was "kicking and screaming." An RN note, dated 1/03/10 at 10:25 PM, documented application of four point soft restraints. The note documented police officers participated in restraint application. An RN note, dated 1/03/10 at 11:00 AM documented RN monitoring of restraints. This was 35 minutes after application of restraints (20 minutes beyond the minimum required time for restraint monitoring according to hospital policy). The next documenation of restraint monitoring was at 11:30 PM on 1/03/10 and midnight on 1/04/10, both 30 minutes after the previous monitoring (15 minutes beyond the minimum required time for	A 175		

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A 175	Continued From page 7 restraint monitoring). Restraints were removed at 12:45 AM on 1/04/10. RN notes, dated 1/03/10 at 10:25 PM, 11:00 PM, through 1/04/10 at 12:45 AM indicated police officers were "sitters." There was no evidence of continuous monitoring by an assigned staff member who was competent and trained in the use of restraints. During an interview on 5/26/10 at 10:50 AM, the Vice President of Patient Care Services reviewed Patient #1's record and confirmed ED documentation failed to show consistent monitoring of patients in restraints every 15 minutes according to hospital policy. He also confirmed the use of police officers to fulfill the requirement for sitters. Hospital staff did not monitor Patient #1 while she was restrained consistent with hospital policy. 2. Patient #16 was a 30 year old male who arrived at the ED on 12/11/09 via police escort. A physician's order for two point restraints, dated 12/11/09 at 7:30 PM, was documented in the medical record on a form titled "Violent Adult (Behavioral) Restraint Order." The restraint order failed to include the specific type of restraint (whether soft or leather or other). It also failed to indicate which limbs were to be restrained or the clinical justification for the restraints. A nursing note, dated 12/11/09 at 7:30 PM documented police had handcuffed the patient's arms to the bed and soft restraints had been applied to his legs. During an interview on 5/25/10 at 10:15 AM, ED RN #1 reviewed Patient #16's medical record and confirmed incomplete restraint order documentation.	A 175		

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A 175	Continued From page 8 Monitoring of restraints for Patient #16 exceeded, at times, the 15 minute minimum requirement established by hospital policy. An RN note documented monitoring on 12/11/09 at 8:27 PM, followed by 8:58 PM, 31 minutes later, 9:05 AM, and then at 9:30 AM, 25 minutes later, again at 10:10 PM, 40 minutes later. Several nursing notes, including 12/11/09 at 9:05 PM, 9:30 PM, 10:10 PM, 10:35 PM, documented "police" were present as Patient #16's sitter. There was no evidence of continuous monitoring by an assigned staff member who was competent and trained in the use of restraints. The hospital failed to ensure monitoring of restrained patients at intervals expected in hospital policy. It also failed to monitor, or document monitoring, of patients for all aspects of monitoring required in hospital policy.	A 175		
A 208	482.13(f)(4) PATIENT RIGHTS: RESTRAINT OR SECLUSION Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed. This STANDARD is not met as evidenced by: Based on staff interview and review of hospital personnel records, it was determined the hospital failed to document successful completion of hands-on restraint competencies for 4 of 6 ED RNs (#1, #2, #3, and #4) whose personnel records were reviewed for restraint competencies. This had the potential to result in restraints being completed by unqualified RNs. Findings include:	A 208		

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A 208	Continued From page 9 During an interview on 5/25/10 at 9:40 AM, the Clinical Nurse Educator in charge of restraint education stated hands on return-demonstration of restraint use was not part of the initial or annual restraint education that she provided for employees. She stated hands-on demonstration of restraint usage was a unit specific task at initial hire/orientation. She explained staff were expected to pass a written test to show knowledge regarding restraints. She stated that as long as she has been the Clinical Nurse Educator (since 2007) there had been no hands-on verification of restraint competencies during annual restraint education. She stated that RNs were expected to know how to apply restraints because it was taught in nursing school. An Emergency Department Orientation Checklist (used for new hires) had one line dedicated to restraint competencies. The line read "able to care for patients in Behavioral and Medical restraints and adheres to the policies and procedures." This was a general statement and did not allow confirmation of specific hands-on restraint competencies, such as the demonstration of safe application and use of all types of restraints used in the hospital. During an interview on 5/25/10 at 10:15 AM, ED RN #1 confirmed she was required to do a return demonstration in the ED upon initial orientation. Staff personnel records for ED RN #1 (doh 5/02/05), ED RN #2 (doh 4/07/08), ED RN #3 (doh 6/01/02), and ED RN #4 (doh 5/18/87) failed to document the successful demonstration of hands-on restraint competencies either upon orientation or since the initial hire date.	A 208		

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A 208	Continued From page 10 The hospital failed to ensure documentation in personnel records of all restraint competencies.	A 208		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure nursing staff supervised and evaluated the nursing care related to wound care and/or pain management for 3 of 6 medical/surgical patients (#14, #19, and 23), whose records were reviewed for wound and pain care. This resulted in the failure of nurses to respond to patients' needs. Findings include: 1. Patient #14's medical record documented a 75 year old female who was admitted to the hospital on 5/26/09 for placement of a suprapubic catheter and a pubovaginal sling. She was discharged home on 5/28/09. A "PRE-OP ASSESSMENT," dated 5/26/09 at 1:18 PM, stated Patient #14 weighed 301 pounds and was 5 feet 0 inches tall. She had a left below the knee amputation. A progress note by the Wound Care Nurse, dated 5/27/09 at 1:45 PM, stated Patient #14 was unable to do any cares for herself. The note said Patient #14 was reluctant to be turned and only got out of bed at home with a Hoyer lift. The note documented skin breakdown in the skin folds of her abdomen, right buttock, and "other skin folds." The note stated it was a "Most challenging situation [due to] pressure, obesity & constant moisture."	A 395		

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A 395	Continued From page 11 The Director of the Medical/Surgical Unit was interviewed on 5/26/10 at 10:05 AM. She stated it was very difficult to turn Patient #14 and provide personal cares due to her obesity. Patient #14's final "Patient's Care Plan," dated 5/26/09 and 5/27/09, stated "Integumentary...Potential/actual alteration in integumentary system related to disease process, aging, trauma and/or surgical procedures. ASSESSMENT: Integumentary-PROTOCOL: SKI INT." A specific plan to prevent skin break down and provide personal care and assistance with activities of daily living was not included in the POC. The Wound Care Nurse documented evaluating and treating Patient #14 on 5/27/09 at 1:45 PM. She wrote wound care orders at that time including orders to turn Patient #14 every 2 hours and apply barrier creme and powders. Nursing notes did not document turning Patient #14 or other wound care prior to the Wound Care Nurse's visit. After the visit, repositioning Patient #14 was documented on 5/27/09 at 10 PM and on 5/28/09 at 12:05 AM, 4:00 AM, 8:25 AM, and 4:36 PM. No other notes documenting repositioning Patient #14 were documented. The Director of the Medical/Surgical Unit was interviewed on 5/26/10 at 10:05 AM. She confirmed care to prevent skin breakdown was not consistently provided for Patient #14. 2. Patient #19's medical record documented a 78 year old female who was admitted to the hospital on 4/09/10 with diagnoses of acute and chronic kidney disease, cellulitis of her right toe, and diabetes type II. She was discharged on 4/13/10.	A 395		

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A 395	Continued From page 12 The "PATIENT ASSESSMENT," dated 4/09/10 at 8:30 PM, stated the Patient #19 had cellulitis to mid-calf. The Assessment did not mention skin breakdown. A picture of Patient #19's buttocks on 4/11/10 at 12:30 AM, showed extensive excoriation of her buttocks and a 1/2 cm open area on her right buttock. Patient #19's final "Patient's Care Plan," dated 4/09/10, 4/10/10, and 4/11/10, stated "Integumentary...Potential/actual alteration in integumentary system related to disease process, aging, trauma and/or surgical procedures. Integumentary status will be monitored." A specific plan to prevent skin break down was not included in the POC. Patient #19 was seen by the wound nurse at 1:10 PM on 4/12/10. A progress note and orders were written at that time for turning and protective cream. The only nursing notes documenting repositioning Patient #19 and other interventions to prevent skin break down were written on 4/10/10 at 6:45 PM and on 4/11/10 between 12:00 noon and 2:30 PM. No other notes documenting the repositioning of Patient #19 were present. The Director of the Medical/Surgical Unit was interviewed on 5/26/10 at 10:05 AM. She confirmed care to prevent skin breakdown was not consistently provided for Patient #19. 3. Patient #23 was a 45 year old female who was admitted on 11/04/09 for a laparoscopic hysterectomy. According to the hospital's electronic documentation, on the patient assessment page of the Nursing Admission	A 395		

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A 395	Continued From page 13 Assessment, dated 11/04/09 at 11:35 AM, Patient #23 indicated her pain goal was 3/10. According to Patient #23's eMAR, she received 30 mg of Toradol (medication for pain) on 11/4/09 at 3:59 PM, however there was no documentation of Patient #23's pain level or characteristics of her pain. At the bottom of the eMAR was a reminder for RNs to, "Remember to Reassess." There was no evidence of re-assessment of Patient #23's pain after administration of Toradol. In the hospital's patient assessment document, under the heading pain assessment, on 11/04/09 at 8:30 PM, documented Patient #23's pain level at 9/10. Within the same document, under the heading pain-response to intervention/note, was written, "Given 2 tablets of Norco (medication for pain)." A review of the hospital's eMAR confirmed the Norco was given at approximately that time and on that date. There was no evidence of re-assessment of Patient #23's pain after administration of Norco. The next documentation of Patient #23's pain level (7/10) occurred on 11/04/09 at 11:24 PM. The record continued with, "Given Toradol. Headache subsiding from past Norco dose." The administration of Toradol was documented on the eMAR as Toradol 30 mg given at 11:22 PM. The time between assessments of Patient #23's pain was 2 hours and 54 minutes. On 11/05/09 at 6:09 AM, the RN documented Patient #23's pain level at 8/10 with the additional note documenting that 2 tablets of Norco were given. There was no evidence of re-assessment of Patient #23's pain after administration of Norco. The time between pain assessments was	A 395		

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A 395	Continued From page 14 2 hours and 9 minutes. On 11/05/09 at 8:38 AM, the RN documented Patient #23's pain level at 3/10 with the additional note documenting, "Toradol given." The time between this pain assessment and the previous pain assessment was 2 hours and 29 minutes. Again, Toradol was documented on Patient #23's eMAR as given 9:11 AM on 11/05/09, without assessment of Patient #23's pain level or its characteristics. On 11/05/09 at 9:52 AM, the RN documented, "PT (patient) states the pain is feeling much better." There was no documentation of the patient's pain level. On 6/2/10 at 10:55 AM, a phone interview was held with the Director of the Medical/Surgical Unit. She confirmed that there was no documentation of Patient #23's pain level or characteristics before the administration of the Toradol on 11/04/09 at 3:59 PM and again on 11/05/09 at 9:11 AM. She stated she was unsure that those fields were able to be documented. 4. A review of the hospital's comprehensive policy titled, "Pain Management Multidisciplinary Policy and Procedure," last revision 11/09, stated, "Assess characteristics of pain..." The policy further stated, "A positive response to pain assessment, either verbal or non-verbal, requires intervention and reassessment following intervention. The patient's pain status is reassessed at least once a shift, 30 minutes to one hour after the pain relieving interventions or medication administration, and as needed." This was not done.	A 395		

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A 395	Continued From page 15 On 6/2/10 at 10:55 AM, a phone interview was held with the Director of the Medical/Surgical Unit. She confirmed that the hospital's policy for pain management was pain re-assessments to be done at least every shift, 30 minutes to one hour after pain medication was administered. The hospital failed to follow its policy in reassessing the patient's pain level and characteristics following administration of medications.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure nursing staff developed and kept current a nursing care plan for 6 of 7 medical/surgical patients (#14, #17, #18, #19, #20 and #23), whose records were reviewed for nursing POC. This resulted in a lack of direction to nursing staff caring for patients and had the potential to interfere with patient care. Findings include: 1. Patient #14's medical record documented a 75 year old female who was admitted to the hospital on 5/26/09 for placement of a suprapubic catheter and a pubovaginal sling. She was discharged home on 5/28/09. A "PRE-OP ASSESSMENT," dated 5/26/09 at 1:18 PM, stated Patient #14 weighed 301 pounds and was 5 feet 0 inches tall. She had a left below	A 396		

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A 396	Continued From page 16 the knee amputation. A progress note by the Wound Care Nurse, dated 5/27/09 at 1:45 PM, stated Patient #14 was unable to do any cares for herself. The note said Patient #14 was reluctant to be turned and only got out of bed at home with a Hoyer lift. The note said Patient #14 was reluctant to be turned. The note documented skin breakdown in the skin folds of her abdomen, right buttock, and "other skin folds." The note stated it was a "Most challenging situation [due to] pressure, obesity & constant moisture." The Director of the Medical/Surgical Unit was interviewed on 5/26/10 at 10:05 AM. She stated it was very difficult to turn Patient #14 and provide personal cares due to her obesity. Patient #14's final "Patient's Care Plan," dated 5/26/09 and 5/27/09, stated "Integumentary...Potential/actual alteration in integumentary system related to disease process, aging, trauma and/or surgical procedures. ASSESSMENT: Integumentary-PROTOCOL: SKI INT." A specific plan to prevent skin break down and provide personal care and assistance with activities of daily living was not included in the POC. The Medical Records Technician was interviewed on 5/24/10 at 4:10 PM. She stated the medical record including the POC was complete. The nursing POC did not address Patient #14's needs. 2. Patient #17's medical record documented a 71 year old male who was admitted to the hospital on 2/13/10 for generalized weakness following a fall. He was discharged on 2/15/10. The "PATIENT	A 396		

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A 396	Continued From page 17 ASSESSMENT," dated 2/14/10 at midnight, stated Patient #17 was disoriented and forgetful and had weakness in all 4 extremities. The assessment stated he had a skin tear on his right elbow. The assessment stated he had a urinary catheter. A Nursing Shift Assessment, dated 2/14/10 at 9:00 AM, stated he was a high fall risk. Patient #17's POC was not specific. For example, his POC stated "GU/Reproductive-Focused Assessment Potential/actual alteration in Genitourinary/reproductive system related to disease process, aging, surgical procedures, trauma, and/or pregnancy. The patient's GU&/or Reproductive function/status will be monitored, maintained/improved." Interventions included "ASSESSMENT: GU/Reproductive-PROTOCOL: SUP CAT *Discontinue of Foley Catheter *INTERVENTIONS: Genitourinary-PROTOCOL: SUP CAT." This was the most specific plan listed for Patient #17. It was not clear what the plan was directing staff to do. No attempts to discontinue Patient #17's catheter were documented. Catheter care was not documented during the patient's stay. The Director of the Medical/Surgical Unit and the Supervisor of Case Management were interviewed together on 5/26/10 at 10:05 AM. They stated, if a nurse checked a box on a computer screen, that would lead to other boxes the nurse could check. They conceded specific interventions were not documented on the POC. The nursing POC did not address Patient #17's needs. 3. Patient #19's medical record documented a 78	A 396		

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A 396	Continued From page 18 year old female who was admitted to the hospital on 4/09/10 with diagnoses of acute and chronic kidney disease, cellulitis of her right toe, and diabetes type II. She was discharged on 4/13/10. The "PATIENT ASSESSMENT," dated 4/09/10 at 8:30 PM, stated the Patient #19 had cellulitis to mid-calf. The Assessment did not mention skin breakdown. A picture of Patient #19's buttocks on 4/11/10 at 12:30 AM, showed extensive excoriation of her buttocks and a 1/2 cm open area on her right buttock. Patient #19's final "Patient's Care Plan," dated 4/09/10, 4/10/10, and 4/11/10, stated "Integumentary...Potential/actual alteration in integumentary system related to disease process, aging, trauma and/or surgical procedures. Integumentary status will be monitored." A specific plan to prevent skin break down was not included in the POC. Patient #19 was seen by the Wound Care Nurse at 1:10 PM on 4/12/10. A progress note and orders were written at that time for turning and protective cream. The nursing POC was not updated to include the Wound Care Nurse's recommendations. The Vice President for Patient Care Services was interviewed on 5/26/10 at 1:45 PM. He stated the electronic medical record made personalization of POCs difficult. He stated the hospital was looking for systems that would allow greater specification of POCs. The nursing POC did not address Patient #19's skin care needs. 4. Patient #20's medical record documented an 86 year old female who was admitted to the hospital on 4/16/10 for altered mental status. She	A 396		

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A 396	Continued From page 19 was discharged to an ALF on 4/21/10. A "T-sheet" (a.k.a. triage sheet), used in the ED for physicians to document assessments of patients seen in the ED, dated 4/16/10 and signed, but not timed, checked off Patient #20's skin as warm and dry and intact. However, a nursing note, undated, untimed, documented Patient #20 as having had fragile skin issues and "alteration-unsure, duoderm on right hip. Patient arrived from ED with bandage." Further documentation of Patient #20's fragile skin condition was shown in the ALF's MAR with a physician order dated 3/15/10, for Baza skin barrier cream. Patient #20's "Patient's Care Plan," dated 4/16/10, stated, "Integumentary...Potential/actual alteration in integumentary system related to disease process, aging, trauma and/or surgical procedures. ASSESSMENT: Integumentary-PROTOCOL: SKI INT." Physician Orders, dated 4/17/10 at 11:30 AM, documented orders for an air mattress for skin issues and a wound care consult. There was no evidence that the air mattress or wound care was included in Patient #20's POC. On 4/17/10 at 11:30 AM, the RN documented in the Patient Assessment, "Air overlay mattress for decub on RT (right) hip. Wound Care RN to see PT (patient) for wound on RT hip." On 4/19/10 at 10:00 AM, the Wound Care Nurse documented in the hospital's Physician's Note paper document that Patient #20 had a stage II decubiti on the right coccyx. In addition, there was a signed order to turn Patient #20 every 2	A 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130013	A. BUILDING _____ B. WING _____	C 06/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 396	Continued From page 20 hours, change dressings every Monday, Wednesday, and Friday, cleanse with wound cleanser, apply skin barrier, dress with foam, and to float her heels. There was no documentation that Patient #20's POC was updated to include the Wound Care Nurse's recommendations. The Director of the Medical/Surgical Unit and the Supervisor for Case Management were interviewed together on 5/26/10 at 10:05 AM. They stated, if a nurse checked a box on a computer screen, that would lead to other boxes the nurse could check. They conceded patient specific interventions were not documented on the POC. The nursing POC did not address Patient #20's specific skin care needs or include physician's skin care orders. 5. Patient #23's medical record documented a 45 year old female who was admitted to the hospital on 11/04/09 for a laparoscopic hysterectomy. She was discharged home on 11/05/09. Patient #23's "Patient's Care Plan," dated 11/04/09, stated, "ASSESSMENT: Pain Management/Reassessment - PROTOCOL: PAI MGT." A specific plan to manage Patient #23's pain was not included in the POC. The Director of the Medical/Surgical Unit and the Supervisor for Case Management were interviewed together on 5/26/10 at 10:05 AM. They stated, if a nurse checked a box on a computer screen, that would lead to other boxes the nurse could check. They conceded patient specific interventions were not documented on the POC.	A 396		

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A 396	Continued From page 21 The nursing POC did not address Patient #23's pain management needs. 6. Patient #18's medical record documented a 65 year old male who was admitted to the hospital on 2/12/10 for shortness of breath. He was discharged home on 2/15/10. Patient 18's "Patient's Care Plan," dated 2/12/10, stated, "Respiratory Interventions..Respiratory problems related to disease process, trauma, or surgery. ASSESSMENT: RT: INTERVENTIONS-PROTOCOL: Res The." A specific plan to address Patient #18's breathing difficulties was not included in the POC. In an interview with the Supervisor of Case Management on 5/26/10 at 11:17 AM, she confirmed the current documentation system has flaws and the hospital, "...has changed its system so that all services and assessments are done in the same system." She produced further proof of change with the minutes of the Oversight Committee meeting minutes dated 2/25/10. The nursing POC did not address Patient #18's specific respiratory needs. 7. The Director of the Medical/Surgical Unit, interviewed on 5/26/10 at 2:00 PM, stated the hospital did not have a policy specific to POCs. She provided surveyors with a policy titled "STANDARDS OF NURSING PRACTICE WITH ROLE DIFFERENTIATION," revised January 2006. The policy stated "The RN will: 4. Develop a plan of care...6. Revise the plan of care and/or	A 396		

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A 396	Continued From page 22 expected outcomes as necessary to ensure progress towards desired outcomes." The policy did not provide direction as to how this would be done. The Director of the Medical/Surgical Unit was interviewed on 6/02/10 at 11:00 AM. She provided surveyors with a training module titled "Plan of Care." The module was not dated. It explained the physical process of data entry for the POC but it did not discuss what type of information should be entered or how to individualize the POC so it was specific to the patient. The Director of the Medical/Surgical Unit stated a policy discussing the content of the medical record had not been developed. The Vice President for Patient Care Services was interviewed on 5/26/10 at 1:45 PM. He stated the electronic medical record made personalization of POCs difficult. He stated the hospital was looking for systems that would allow greater specification of POCs. The hospital failed to ensure the nursing staff developed and kept current nursing care plans for its patients.	A 396		